Elaine D. Stephens, RN, MPH
Chairman of the Board

HOMECARE & HOSPICE
NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

Val J. Halamandaris, JD
President

TESTIMONY

BEFORE THE
SMALL BUSINESS COMMITTEE
SUBCOMMITTEE ON CONTRACTING AND TECHNOLOGY
UNITED STATES HOUSE OF REPRESENTATIVES

ON

PLAIN LANGUAGE IN PAPERWORK-- THE BENEFITS TO SMALL BUSINESS

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PRESENTED BY

Christine Grundmeyer, RN
Administrator, Auxi Health Services
16 First Street SW
Oelwein, IA 50662

ON BEHALF OF THE

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
228 Seventh Street, S.E.
Washington, D.C. 20003

AND

IOWA ASSOCIATION FOR HOME CARE
1520 High Street
Des Moines, Iowa 50309

Thank you Mr. Chairman, Ranking Member Davis and Subcommittee members for inviting me to present testimony regarding the use of plain language to reduce the paperwork burden on small businesses. My name is Christine Grundmeyer, and I am a registered nurse. I am the Facility Administrator of Auxi Health Services in northeast Iowa. Auxi Health is a for profit company that is an affiliate of Harden Health Care. Harden Health Care provides a continuum for services that includes assisted living, nursing home, therapy, pharmacy and hospice services. Auxi Health provides skilled nursing, therapy, aide and waiver services to various age groups to enhance independence and wellness in the home. I am president of the Board of Directors of Iowa Alliance in Home Care and a member of the National Association for Homecare and Hospice. Most recently I have been the chairman of the Alliances education committee, a position I have held for the last several years.

NAHC is the largest home health trade association in the nation. Among our members are all types and sizes of Medicare-participating care providers, including nonprofit agencies such as the VNAs, for-profit chains, public and hospital-based agencies and free-standing agencies.

The Iowa Alliance in Home Care (IAHC) is the voice for home care in Iowa, representing the vast majority of home care provider of all types throughout the state. IAHH members strive for compliance with all rules and regulations while taking great pride in the high quality of service we offer to the citizens of Iowa.

Home health agencies are, generally, small businesses. The average home health agency revenue from Medicare, the primary payer of home health services, is under $1.5 million per year. Many of the home health agencies are much smaller, serving sparsely populated areas throughout rural America. Even those home health agencies in large metropolitan cities can be small in size as their services are directed to neighborhoods rather than the city at large.

Operating a home health agency participating in the Medicare program is an extremely complicated series of tasks that requires both management and service personnel to wear many hats. Not only must the staff be capable of providing the highest quality of care in accordance with a physician-prescribed plan of care, they also must be keenly aware of the myriad of regulatory requirements that address virtually every element of day-to-day operations and performance. Effectively, home health agencies must be experts at caregiving and regulatory compliance in order to meet their full range of responsibilities.

Medicare standards for home health agencies address quality of care, financial reporting, and benefit administration. These requirements establish both broad parameters for operations and minute details on recordkeeping. Any divergence from these standards subjects the home health agency to sanctions, including the potential for termination of participation in Medicare.

While the Medicare standards are, by and large, well-intentioned and focused on necessary and important areas such as benefit integrity and appropriateness of care, the complexity of the rules, regulations, and policies easily can lead to more energies and resources applied to compliance assurance than caregiving. Further, the confusion that naturally results from a seemingly endless series of extended guidelines, interpretations, and re-interpretations leaves an impression of a waiting trap for those agencies that do not

keep a cadre of expert regulatory staff and consultants on deck 24/7 to stay on top of the latest version of compliance standards.

In developing this testimony, NAHC has focused on just two of the many Medicare-related regulatory areas that must be addressed on a daily basis by home health agencies. It is our estimation that Medicare rules, regulations, policy guidelines, and interpretations total nearly 10,000 pages. On top of these requirements are those of other federal regulatory heath-related agencies including the Occupational Safety and Heath Administration (OSHA), the Food and Drug Administration (FDA), and the Department of Health and Human Services (HHS) with the electronic billing and patient privacy standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For purposes of this testimony, I highlight two areas of regulation under Medicare where "Plain English" is an elusive element. In fact, if there was a "Plain English" requirement applied to these areas by Medicare in the same manner that the substantive standards of the rules have been implemented, it might take a hundred or more pages to define, redefine, clarify, and explain the meaning of "Plain English."

The two areas of focus in this testimony are the requirements for application of a uniform patient assessment instrument, known as OASIS, and the standards for home health agencies notifying patients regarding the non-coverage of their services under Medicare. While each of these areas are appropriate matters of regulatory concern, the confusion and complex manner in which they are addressed begs for relief if the intended goals of these requirements are to be achieved.

OASIS

The label given to the uniform patient assessment instrument belies its true identity. The Outcomes Assessment and Information Set (OASIS) is the manner by which home health agencies collect and report patient data that is used for outcome measures, public reporting of quality indicators, and case-mix adjustment in the Medicare prospective payment system (PPS) model. OASIS is a series of questions that are used to assess the patient's condition at the start of care and periodically thereafter. While all the questions are included in later quality of care analyses, only 25 are used in the PPS model to determine the case-specific amount of payment.

The goals of OASIS are valid and meritorious. However, the complexity of the regulatory scheme with OASIS is a poster-child for efforts to simplify rules and their administration. The genesis of OASIS is a single statutory provision in the Social Security Act. From that start, the Centers for Medicare and Medicaid Services (CMS) has embarked on a journey of regulatory issuances, interpretative guideline publications, and a growing list of Frequently Asked Questions (FAQ) that demonstrate that simplicity and "Plain English" are a wanting commodity in OASIS.

From the single statutory mandate has sprung 36 pages of the Federal Register on January 25, 1999 and a series of promulgated regulations. 64 F.R. 3748-3784 (January 25, 1999). At that level, the rulemaking seems reasonable, simple, and capable of understanding. However, borne out of the formal rulemaking are interpretive guidelines on conducting a patient assessment with OASIS, developing a patient care plan consistent with the OASIS, and reporting OASIS data to state health officials. These interpretations

of the rules total nearly 50 additional pages along with further references sprinkled throughout hundreds of other related provisions. These are only the OASIS related guidelines that are directed to the quality of care purpose of OASIS.

The payment model elements of OASIS bring an additional 45 pages of guidelines that overlap and sometimes repeat those interpretative guidelines in the quality of care realm. As such, home health agencies must have two sets of guidelines open at the same time to ensure both patient assessment and payment standards are consistently met.

While NAHC members have continually reported confusion with the sets of complex and lengthy OASIS guidelines that have been issued, the most telling sign of this complexity is the issuance of hundreds of "Frequently Asked Questions" (FAQs) by CMS. These FAQs comprise 12 different categories of issues. Categories 1 through 4 alone contain 191 FAQs with many having FAQs within the FAQs. For example, FAQ 113 in Category 4 also contains FAQ 113.1 through 113.3. If these are the number of frequently asked questions, what is the volume of those questions that do not rise to the level of frequency to justify a FAQ?

This testimony should not be considered a criticism of CMS's attempts to bring clarity to a complex area. Instead, NAHC credits CMS for its willingness to assist home health agencies to achieve consistent compliance. However, if CMS is continuing to issue FAQs nearly a decade after the promulgation of the OASIS rule, the message should be that the rule needs a "Plain English" adjustment. It is inconceivable that a rule that requires this level of interpretation and clarification can result in proper application and performance in the real world.

MEDICARE PATIENT NOTICES

Formal written notice is required to advise Medicare beneficiaries when the home health services they seek to receive will not be covered in whole or in part. Notice also is required when coverage or services are terminated or modified. Beneficiary notice is an essential element of fair and reasonable operation of the Medicare home health benefit. However, the complexity of the notice requirements raises serious risks that their purposes will not be achieved.

There are two main notice requirements applicable to Medicare home health agencies. The primary notice form is the Home Health Advance Beneficiary Notice (HHABN). Along with the HHABN is the Expedited Determination Notice. Under the guidelines established by CMS, there are times when both notices are to be presented to the Medicare beneficiary at the same time.

Similar to the OASIS requirements addressed above, the beneficiary notice requirements included statutory and regulatory components along with extensive interpretative guidelines. After navigating hundreds of pages of instructions, home health agencies have the dizzying task of determining which notice is to be given, when is it to be provided, what information is to be included in the notice, what action the agencies must take after the notice, and how do they document the entire notice process. Complexities are added to the process when the Medicare beneficiary is not mentally competent or refuses to accept the notice. Further complications exist when the

beneficiary has an alternative payer for the services. The greatest difficulty occurs when the beneficiary's physician is unwilling to order the care desired by the beneficiary.

While the HHABN and Expedited Determination Notice requirements have been in place since 2001, home health agency staff still today report confusion on how the process is intended to work. What seems to be a simple matter on the surface—Are the services sought covered under Medicare?—has become a compliance nightmare because of the endless exceptions, clarifications, overlapping instructions, and challenges to common sense. Plain English is a foreign concept in the Medicare patient notice realm.

Home health agencies support proper patient notices in changes of coverage or services. However, the current notice structure is its own greatest roadblock to successful patient notice because simplicity is sacrificed for a bureaucratic level of detail that nurses in home care have great difficulty in managing while trying to provide essential health care services.

CONCLUSION

NAHC and IAHC look forward to working with the Subcommittee to address the use of plain language to reduce the paperwork burden on small businesses as outlined in my testimony. This concludes my formal remarks. I would be happy to answer any questions from the Subcommittee members.